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# MEDICAID/PEACHCARE FOR KIDS

## Instructions for Provider Change of Information Form to Reissue a PIN Letter

This form is used to make modifications to provider information maintained in the Georgia Medicaid/PeachCare for Kids (M/PCK) provider system for the purpose of reissuing a Provider PIN letter. Only one provider number may be modified per form.

**Enter the Georgia Medicaid/PeachCare for Kids Provider Number for which changes are being made.**

**1. Current Provider Identification** (Required)
Complete provider's full name or business name as it is currently on file with Georgia M/PCK. Enter the provider's social security and/or Tax Identification number as applicable.

**2. New Address/Telephone Number Information**

**3. Effective Date of Change(s)** (Required)
Report the date on which all listed changes are effective.

**4. Attestation Statement** (Required)
Sign and date this form attesting to the accuracy of the requested changes. If changes are being reported on an individual provider, then that individual must sign this form. If the changes are being reported for an organization or group practice, an authorized representative of the organization or group practice must sign this form to confirm the requested change(s). If you have any questions regarding this form or enrollment requirements, please contact the HP Enterprise Services EDI Team at (877)261-8785. Return this form to:

HP Enterprise Services Provider Enrollment
P. O. Box 105201
Tucker, GA 30085-5201

# MEDICAID/PEACHCARE FOR KIDS

## Provider Change of Information Form to Reissue a PIN Letter

| **Medicaid/PeachCare for Kids Provider Number** (One provider number per form): | |
|---|---|

| **1. Current Provider Identification (Required)** | | | | |
|---|---|---|---|---|
| Name: First | M.I. | Last | Jr., Sr., etc. | MD, DO, etc. |
| Business Name: | | | | |
| Social Security # : (if applicable) | Taxpayer I.D. #: | NPI: | | |

| **2. New Mail-To Address / Telephone Number Information** | | |
|---|---|---|
| New Address Line 1: | | |
| New Address Line 2: | | |
| New City: | New State: | New Zip+4: |
| New Email Address: | New Web Address: | |
| New Telephone #: | New Fax #: | |

| **3. Requested Effective Date of Change(s)** (Required) | This change/these changes are effective as of (MM/DD/YYYY): |
|---|---|

| **4. Attestation Statement** (Required) | |
|---|---|
| I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law. | |
| Provider Authorized Representative's Name (print): | Title: |
| Provider or Authorized Representative's Signature: | Date: |